

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and cemetery filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6658

## CERTIFICATE OF DEATH

06649

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>Elsie Barnett (Elsie May Barnett)</b>				4. DATE OF DEATH <b>June 8 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-1891</b>	9. AGE (In years lost birthday) <b>68</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>6</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Dillman</b>				14. MOTHER'S MAIDEN NAME <b>Corvilla Scarborough</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Charles H. Barnett</b> Address <b>Elkton Rd Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>January 1959</b> to <b>June 8 1959</b> , that I last saw the deceased alive on <b>June 7 1959</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SEB, Md</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Milford H. Sprecher</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leeds Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton Rural Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph B. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
6672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG243 6-15-59 et

Reg. Dist. No.

06650

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>		c. LENGTH OF STAY IN 1b <b>10 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>Robert</b> Last <b>Becker</b>		4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1889</b> 1890
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing and siding</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>No information</b>		14. MOTHER'S MAIDEN NAME <b>No information</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>133-03-2091</b>	
17. INFORMANT Address <b>Mrs. Jacob R. Becker, Rising Sun, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured neck and punctured left upper lobe of Lung.</b> DUE TO (b) <b>Lung.</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of window onto bath tub</b>	
20c. TIME OF INJURY Month, Day, Year <b>June 5 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Rising Sun</b> (County) <b>Cecil</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Porters BRIDGE CEM</b>		22d. LOCATION (City, town, or county) <b>Cecil</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Reed</b>		ADDRESS <b>Rising Sun, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

MEDICAL CERTIFICATION

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Noting the above, the Commission has concluded that the proposed rule is necessary to protect the public interest in the securities markets.

no. 100000000

No. 10-11-12

1902-1903

• Jacob S. Bojarski •

to the extent that the Commission has been able to identify the specific measures taken by the Member States to implement the Directive, it has found that the measures taken have been inadequate to ensure that the Directive is fully implemented.

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1528 J. Neurosci., July 26, 2006 • 26(30):1524–1534

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and camp must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and camp, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6673

## CERTIFICATE OF DEATH

06651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Bennett		4. DATE OF DEATH June 29 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1870 89rs.
9. AGE (In years lost birthday) 89rs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles H. Bennett		14. MOTHER'S MAIDEN NAME Rachael Buckworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 184-22-1774	
17. INFORMANT Alice R. Bennett		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 days some years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10, 1958, to June 29, 1959, that I last saw the deceased alive on June 28, 1959, and that death occurred at 7:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED 6/30/59 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
ADDRESS [Address]		24b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674

## CERTIFICATE OF DEATH

116652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION George St.				d. STREET ADDRESS George St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM K. BORGER				4. DATE OF DEATH June 3, 1959			
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1877		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store-keeper		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Borger				14. MOTHER'S MAIDEN NAME Catherine Schrope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 219-34-4654		17. INFORMANT Mrs. Annie M. Borger Ches. City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO <i>cirrhosis of liver.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition anemia						INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 10, 1958, to June 3, 1959, that I last saw the deceased alive on June 2, 1959, and that death occurred at 5:00 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry V. Davis</i>			M.D. <i>Chesapeake City, Md.</i>			DATE SIGNED 6/4/59	
PHYSICIAN'S NAME (Type) Henry V. Davis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Augustine		22d. LOCATION (City, town, or county) (State) St. Augustine, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home Donald E. Pippin Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and cemetery filled in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 Film G244 7-14-59 et  
6659  
CERTIFICATE OF DEATH

06653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>Cecilton</b>	
3. NAME OF DECEASED (Type or print) First <b>Columbia</b> Middle <b>Boyer</b> Last <b>Boyer</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b> No family left
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE (In years last birthday) <b>76</b> Approx. <b>76</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>U<sup>n</sup> known</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Nellie Washington</b>		Address <b>Cecilton Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascula accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis.</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>  <b>years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Heat exhaustion.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1</b> , 19 <b>59</b> , to <b>30 June 59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>59</b> , and that death occurred at <b>9:15p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilto, Md.</b> DATE SIGNED <b>3 July 59</b> ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D. <b>Cecilto, Md.</b> PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 4, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cecilton Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		24a. REC'D BY REGISTRAR <b>July 7 '59</b>	
ADDRESS <b>Millington Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hunt</b>	



6675

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>			
				f. STREET ADDRESS <b>1</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Thomas Boyer</b>				4. DATE OF DEATH Month Day Year <b>6 11 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-28-1877</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Boyer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Biddle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-24-7693</b>		17. INFORMANT <b>Elsie V. Reed</b>		Address <b>Elkton Rd Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-VASCULAR FAILURE</b> <b>159x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA</b> DUE TO (c) <b>Ca. of G.I. TRACT (COLON)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 DAYS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS / ARTERIOSCLEROTIC CARDIOVASC. DIS.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 7, 1959</b> , to <b>JUNE 11, 1959</b> , that I last saw the deceased alive on <b>JUNE 10, 1959</b> , and that death occurred at <b>3:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecil Ave.</b> DATE SIGNED <b>6-11-59</b> ACTUAL SIGNATURE <b>Luis M. Cuza</b> M.D. <b>North East Md.</b> PHYSICIAN'S NAME (Type) <b>Luis M. Cuza</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06655

6676

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>912 I Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Livingston (NMI) Burgess</b>		4. DATE OF DEATH Month Day Year <b>6 19 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-13-92</b>
9. AGE (In years last birthday) yrs. <b>67</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Burgess</b>		14. MOTHER'S MAIDEN NAME <b>Corn Posey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Not ascertainable</b>	
17. INFORMANT <b>VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism, massive</b> 560.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombosis of left femoral vein</b> DUE TO (c) <b>Herniorrhaphy left 6-16-59</b>		INTERVAL BETWEEN ONSET AND DEATH <b>within 30 min.</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-10</b> , 19 <b>59</b> , to <b>6-19</b> , 19 <b>59</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 6-22-59</b>	
ACTUAL SIGNATURE <b>J. L. GAREY</b>		PHYSICIAN'S NAME (Type) <b>Clinical Pathologist</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myers, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



Remontado a los datos de Gracia, X.

TABLE 1. 2

✓ Hospital, Jerry Jones, 44, 6-22-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06656

6660

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Middle Last Leathe S. Cahall		4. DATE OF DEATH Month Day Year June 26 19 59	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Frances Ann Cahall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Fred Cahall Kenton, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6/16	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1959, to June 26, 1959, that I last saw the deceased alive on June 25, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Clifford H. Greenblum M.D.		J. E. Boulain, M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/59	
22c. NAME OF CEMETERY OR CREMATORY Templeville		22d. LOCATION (City, town, or county) (State) Templeville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulain, Greenblum, Md.		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06657

## CERTIFICATE OF DEATH

Reg. Dist. No.

6677

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chesapeake City		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
3. NAME OF DECEASED (Type or print) First Middle Last ROLAND A. COOLING		4. DATE OF DEATH Month Day Year June 15, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1906
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY C. and D. Canal	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Cooling		14. MOTHER'S MAIDEN NAME Mary E. Arrants	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Gertrude H. Cooling		Address Chesapeake City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary artery disease DUE TO with angina pectoris (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH none unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 54, to June 15 59, that I last saw the deceased alive on June 1 59, and that death occurred at 8 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. RA LPH A NDREWS, JR.		M.D. 233 E. Main Street 6/16/59	
PHYSICIAN'S NAME (Type) S. RA LPH A NDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/18/1959	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06658

6661

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William M. Corriden</u>				4. DATE OF DEATH Month Day Year <u>June 12, 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DuPont Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frank Corriden</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Coizer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-05-3864</u>				17. INFORMANT Address <u>Mrs. Grace S. Corriden, Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Elkton</u>				20g. (County) <u>Cecil</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>June 10</u> 19 <u>59</u> to <u>June 12</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 11</u> 19 <u>59</u> , and that death occurred at <u>11:45p</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				DATE SIGNED <u>6/13/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							



6678

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>20yrs. 7mo. 27days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SHERMAN</b> Middle <b>(NMI)</b> Last <b>DIZE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>(Day and 1892 Month unk.) 67</b> yrs.	
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.		11. AGE (In years lost birthday) <b>67</b> yrs.		12. IF UNDER 24 HRS. Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dredger</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Louis Dize (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Evans (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-I</b>				16. SOCIAL SECURITY NO. <b>Not available</b>			
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia right lower lobe, unresolved</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease, Severe</b> DUE TO (c) <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized &amp; cerebral, severe</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m. <b>11:30pm</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 26, 1938, to June 22, 1959</b>				22. I certify that I attended the deceased from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. L. Garey</b>				ADDRESS (Street, city or town, state) <b>M.D. V.A. Hospital, Perry Point, Md. 6-23-59</b>			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				22b. DATE THEREOF <b>6/24/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield</b>				22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6679

CERTIFICATE OF DEATH

06660

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Pocomoke City</b> <b>2342.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>604 Market</b>	
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>E.</b> Last <b>DRYDEN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 21, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>4</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Registered</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM TUMBLIN DRYDEN</b>		14. MOTHER'S MAIDEN NAME <b>LYDIA CANNON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. ADDRESS <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia, bilateral, unresolved</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24-48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 21, 1951</b> to <b>June 13, 1959</b> , and that death occurred at <b>3:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. L. GAREY, M.D.</b>		ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b>		DATE SIGNED <b>6-14-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S EPISCOPAL</b>		22d. LOCATION (City, town, or county) (State) <b>POCOMOKE CITY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. Watson</b> <b>WATSON FUNERAL HOME, Pocomoke City, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6662

## CERTIFICATE OF DEATH

Reg. Dist. No.

06661

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gilbert</b> Middle <b>Edwards</b> Last <b>Edwards</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Labor</b>	
11. BIRTHPLACE (State or foreign country) <b>Earleville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gilbert Edwards Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>155-09-0300</b>	
17. INFORMANT <b>Phillip Edwards</b>		Address <b>40 Pershing Ave. Cartert, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia, Diabetes mellitus (Hepato-renal failure?)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b> <b>year.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 26</b> , 19 <b>59</b> , to <b>June 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace O'Brien</b>		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>1 July 59</b>	
PHYSICIAN'S NAME (Type) <b>WALLACE O'BRENSHAIN</b>		<b>CECILTON, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Pellosar</b>		ADDRESS <b>Millington Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE</b> <b>Jul 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06662

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Mills</u> d. STREET ADDRESS <u>Elk Mills</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Ellen Forester</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>6 14 19 59</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-9-1888</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Keeping house</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Johnson Co. Tenn</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Scott Head</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>May FORRESTER</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>— — — — —</u>				<b>17. INFORMANT</b> Address <u>Denver Forrester, R.D.# 1, Elkton, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Cerebral <del>anast</del> Accident Conoary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>R.C. Dodson</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>6-14-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-8-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Elkton Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Elkton, Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Pippin Funeral Home</u> <u>Elkton, Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUN 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# ARVAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18 RAY'S MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased [Name]		Sex [Male/Female]		Date of Birth [Date]		Place of Birth [Place]	
Usual Residence [Address]		Date of Death [Date]		Time of Death [Time]		Cause of Death [Cause]	
Medical History [History]		Present Illness [Illness]		Post-mortem Examination [Examination]		Remarks [Remarks]	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]		Signature of Burial Officer [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6664 Item 9 Film 6244 6-25-59 et  
CERTIFICATE OF DEATH

06663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cecil b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Betty J. Gross		4. DATE OF DEATH Month Day Year 6 19 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1916
9. AGE (In years last birthday) 42 2/3 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sinnett J. Justice	
14. MOTHER'S MAIDEN NAME Lilly Belle Justice		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Donna Batalis Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal CARCINOMATOSIS 1750 DUE TO (b) Carcinoma of ovary DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 12 MONTHS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10, 1959, to 6/19, 1959, that I last saw the deceased alive on 6/18, 1959, and that death occurred at 5:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Fischer M.D.		ADDRESS (Street, city or town, state) 162 W MAIN ST. DATE SIGNED 6/19/59	
PHYSICIAN'S NAME (Type) John A. Fischer ELKTON, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6/19/59	22c. NAME OF CEMETERY OR CREMATORY Radfield Cem. Welch, West Virginia	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Small M. Bee Elkton, MD		24a. REC'D BY REGISTRAR DATE JUN 22 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARYLAND		2. SEX MALE		3. AGE 20	
4. DATE OF DEATH JAN 10 1918		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH PNEUMONIA		8. DISEASE OR INJURY PNEUMONIA		9. PLACE OF BIRTH BALTIMORE, MARYLAND	
10. OCCUPATION LABORER		11. MARITAL STATUS SINGLE		12. COLOR WHITE	
13. NAME OF PHYSICIAN DR. J. H. BROWN		14. NAME OF FUNERAL HOME J. H. BROWN		15. NAME OF BURIAL PLACE CATHOLIC CEMETERY	
16. NAME OF WITNESS J. H. BROWN		17. NAME OF WITNESS J. H. BROWN		18. NAME OF WITNESS J. H. BROWN	
19. NAME OF WITNESS J. H. BROWN		20. NAME OF WITNESS J. H. BROWN		21. NAME OF WITNESS J. H. BROWN	
22. NAME OF WITNESS J. H. BROWN		23. NAME OF WITNESS J. H. BROWN		24. NAME OF WITNESS J. H. BROWN	
25. NAME OF WITNESS J. H. BROWN		26. NAME OF WITNESS J. H. BROWN		27. NAME OF WITNESS J. H. BROWN	
28. NAME OF WITNESS J. H. BROWN		29. NAME OF WITNESS J. H. BROWN		30. NAME OF WITNESS J. H. BROWN	
31. NAME OF WITNESS J. H. BROWN		32. NAME OF WITNESS J. H. BROWN		33. NAME OF WITNESS J. H. BROWN	
34. NAME OF WITNESS J. H. BROWN		35. NAME OF WITNESS J. H. BROWN		36. NAME OF WITNESS J. H. BROWN	
37. NAME OF WITNESS J. H. BROWN		38. NAME OF WITNESS J. H. BROWN		39. NAME OF WITNESS J. H. BROWN	
40. NAME OF WITNESS J. H. BROWN		41. NAME OF WITNESS J. H. BROWN		42. NAME OF WITNESS J. H. BROWN	
43. NAME OF WITNESS J. H. BROWN		44. NAME OF WITNESS J. H. BROWN		45. NAME OF WITNESS J. H. BROWN	
46. NAME OF WITNESS J. H. BROWN		47. NAME OF WITNESS J. H. BROWN		48. NAME OF WITNESS J. H. BROWN	
49. NAME OF WITNESS J. H. BROWN		50. NAME OF WITNESS J. H. BROWN		51. NAME OF WITNESS J. H. BROWN	
52. NAME OF WITNESS J. H. BROWN		53. NAME OF WITNESS J. H. BROWN		54. NAME OF WITNESS J. H. BROWN	
55. NAME OF WITNESS J. H. BROWN		56. NAME OF WITNESS J. H. BROWN		57. NAME OF WITNESS J. H. BROWN	
58. NAME OF WITNESS J. H. BROWN		59. NAME OF WITNESS J. H. BROWN		60. NAME OF WITNESS J. H. BROWN	
61. NAME OF WITNESS J. H. BROWN		62. NAME OF WITNESS J. H. BROWN		63. NAME OF WITNESS J. H. BROWN	
64. NAME OF WITNESS J. H. BROWN		65. NAME OF WITNESS J. H. BROWN		66. NAME OF WITNESS J. H. BROWN	
67. NAME OF WITNESS J. H. BROWN		68. NAME OF WITNESS J. H. BROWN		69. NAME OF WITNESS J. H. BROWN	
70. NAME OF WITNESS J. H. BROWN		71. NAME OF WITNESS J. H. BROWN		72. NAME OF WITNESS J. H. BROWN	
73. NAME OF WITNESS J. H. BROWN		74. NAME OF WITNESS J. H. BROWN		75. NAME OF WITNESS J. H. BROWN	
76. NAME OF WITNESS J. H. BROWN		77. NAME OF WITNESS J. H. BROWN		78. NAME OF WITNESS J. H. BROWN	
79. NAME OF WITNESS J. H. BROWN		80. NAME OF WITNESS J. H. BROWN		81. NAME OF WITNESS J. H. BROWN	
82. NAME OF WITNESS J. H. BROWN		83. NAME OF WITNESS J. H. BROWN		84. NAME OF WITNESS J. H. BROWN	
85. NAME OF WITNESS J. H. BROWN		86. NAME OF WITNESS J. H. BROWN		87. NAME OF WITNESS J. H. BROWN	
88. NAME OF WITNESS J. H. BROWN		89. NAME OF WITNESS J. H. BROWN		90. NAME OF WITNESS J. H. BROWN	
91. NAME OF WITNESS J. H. BROWN		92. NAME OF WITNESS J. H. BROWN		93. NAME OF WITNESS J. H. BROWN	
94. NAME OF WITNESS J. H. BROWN		95. NAME OF WITNESS J. H. BROWN		96. NAME OF WITNESS J. H. BROWN	
97. NAME OF WITNESS J. H. BROWN		98. NAME OF WITNESS J. H. BROWN		99. NAME OF WITNESS J. H. BROWN	
100. NAME OF WITNESS J. H. BROWN		101. NAME OF WITNESS J. H. BROWN		102. NAME OF WITNESS J. H. BROWN	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6680

## CERTIFICATE OF DEATH

06664

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2703 Baker Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>GROSS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 9, 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>1</b> Min. <b>4</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Gross</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Sisco</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>		16. SOCIAL SECURITY NO. <b>19 03 3489</b>	
INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Liver (Hepatoma)</b> <b>155.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 2 mths.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26, 1959</b> to <b>June 25, 1959</b> and that death occurred at <b>2:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>6-25-59</b>			
ACTUAL SIGNATURE <b>J. R. Garcia-Velez</b>		M.D. <b>J. R. Garcia-Velez, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>J. R. GARCIA-VELEZ, M.D.</b>		<b>Perry Point, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George E. Kelson</b>		ADDRESS <b>1348 N. Calhoun St., Balto., Md.</b>	
24a. REC'D BY REGISTRAR <b>DOWN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. After the certificate is filed, the funeral director should detach the far side of the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06665

6681

## CERTIFICATE OF DEATH

Reg. Dist. No.

97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Massachusetts</u> b. COUNTY <u>Plymouth</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norwell</u> 58 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S.N. Hosp.</u>		d. STREET ADDRESS <u>Washington</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lester</u> Last <u>Holland Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1959</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>58</u> Days <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Robert Lester Holland Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Irma delos Angeles Pina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 50 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June</u> , 19 <u>59</u> , to <u>10 June</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10 June</u> , 19 <u>59</u> , and that death occurred at <u>10:44 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen P. Hartman</u>		ADDRESS (Street, city or town, state) <u>M.D. U. S. Naval Hospital, Bainbridge, Maryland</u>	
DATE SIGNED <u>6/11/59</u>			
PHYSICIAN'S NAME (Type) <u>ALLEN P. HARTMAN LT MC USNR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 June 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colora, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>		ADDRESS <u>PERRYVILLE, MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	





06666

6682

# CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>23 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN</b> First <b>WINFIELD</b> Middle <b>JONES</b> Last		4. DATE OF DEATH <b>6</b> Month <b>21</b> Day <b>59</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-3-93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Tobacco)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming (Own)</b>	9. AGE (In years lost birthday) yrs. <b>65</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Jefferson Jones</b>		14. MOTHER'S MAIDEN NAME <b>Edith (Duvall) Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. ADDRESS <b>Hospital Records, VAH, Perry Point, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>350x</b> DUE TO <b>Aspiration of foreign material (Food and Saliva)</b> Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>Paralysis' Agitans (Parkinsonian Syndrome), severe</b> (c) <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>X</b> attended the deceased from <b>7-3-</b> <b>1936</b> to <b>6-21-</b> <b>1959</b> , and that death occurred at <b>9:35a</b> M, from the causes and on the date stated above <b>ADDRESS (Street, city or town, state)</b> <b>DATE SIGNED</b> <b>6/21/59</b>			
ACTUAL SIGNATURE <b>S. P. LA CERVA</b> M.D. <b>DIRECTOR; PROFESSIONAL SERVICES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leeland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Harris</b>		24. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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CERTIFICATE OF DATA

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Prince Georges

Langford

Good

British

25 years

Point Fort

Home

Veterans Administration Hospital

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JONES

WINSTON

HELMUTH

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11-3-53

White

Male

USA

Langford

Langford

Langford

Langford

Langford (Langford Jones)

Langford (Langford Jones)

Langford, VA, Point Fort, MA.

Langford

Yes

1 to 6 yrs

Proteinuria, bilateral

Admission of foreign material (Food and Native)

Unknown

Paralysis, Arthritis (Paraneoplastic Syndrome)

Severe

1

8-21-53

7-2-53

8:55

XXXXXXXXXXXXX

Langford; Professional Services

8.2. LA. 12.12.12.

Langford, VA, Point Fort, MA.

Langford

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6665

## CERTIFICATE OF DEATH

06667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>4 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Logan</b>				4. DATE OF DEATH Month Day Year <b>June 29 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-29-1959</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John P. Logan</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy W. Widdekind</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-</b>		17. INFORMANT Address <b>John P. Logan North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x Premature infant. Sinc. gestation. wt. 11 lbs. 5 ounces</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature labor - cause undetermined</b> DUE TO (c) <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that I attended the deceased from <b>29 June</b> , 19 <b>59</b> , to <b>29 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>29 June</b> , 19 <b>59</b> , and that death occurred at <b>4 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North East, Md</b> DATE SIGNED <b>29 June '59</b>							
ACTUAL SIGNATURE <b>Klaus H. Hochner</b>		M.D. <b>North East, Md</b>					
PHYSICIAN'S NAME (Type) <b>Klaus H. Hochner M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-30-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

9VVVVVVXVV

CERTIFICATE OF DEATH

1922

Page One

Name of Deceased <b>John B. Bagen</b>		Sex <b>Male</b>		Race <b>White</b>		Age <b>45</b>		Date of Birth <b>1877</b>		Place of Birth <b>England</b>	
Usual Residence <b>John B. Bagen</b>		Place of Death <b>John B. Bagen</b>		Cause of Death <b>John B. Bagen</b>		Manner of Death <b>John B. Bagen</b>		Date of Death <b>John B. Bagen</b>		Time of Death <b>John B. Bagen</b>	
Occupation <b>John B. Bagen</b>		Education <b>John B. Bagen</b>		Religion <b>John B. Bagen</b>		Marital Status <b>John B. Bagen</b>		Previous Illnesses <b>John B. Bagen</b>		Previous Injuries <b>John B. Bagen</b>	
Signature of Physician <b>John B. Bagen</b>		Signature of Coroner <b>John B. Bagen</b>		Signature of Registrar <b>John B. Bagen</b>		Signature of Burial Officer <b>John B. Bagen</b>		Signature of Undertaker <b>John B. Bagen</b>		Signature of Witness <b>John B. Bagen</b>	



Page 4  
death. Within 24 hours  
The law requires that the death certificate be executed within 24 hours of death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6683

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

06668

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4 mos	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		15 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 7815 Exeter Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Malvin T. Love		4. DATE OF DEATH Month Day Year 6 20 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-95
9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doorman		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert K. Love		14. MOTHER'S MAIDEN NAME Nora Tippet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 577 10 0104	
INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Plasma Cell Myeloma (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 3 To 4 dys.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-26-1959, to 6-20-59, and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. GAREY		DATE SIGNED 6-22-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/23/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myers, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Inc.		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Harris	

Chronic bronchitis, bilateral, unresolving

Primary Cell Carcinoma

Arteriosclerosis, generalized, severe

Clinical Pathologist

J. L. BARRY

U.S. Hospital, Long Point, Mo. 6-12-52

Penitentiary, St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6666 CERTIFICATE OF DEATH

06669

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Charlestown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marshall V. Moore				4. DATE OF DEATH Month Day Year June 27 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1906	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Mill		10b. KIND OF BUSINESS OR INDUSTRY Operator		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rudolph Moore				14. MOTHER'S MAIDEN NAME Emily Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-9051		17. INFORMANT Address Mrs. Elizabeth M. Moore Charlestown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 1959, to June 27, 1959, that I last saw the deceased alive on June 14, 1959, and that death occurred at 10:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Milford H. Sprecher M.D.				DATE SIGNED June 28-59			
PHYSICIAN'S NAME (Type) Milford H. Sprecher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/59		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME, 1000 E. Elkton, Md.				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 20b Film 244 6-22-59 6667										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06670				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil										Reg. Dist. No.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bkton					c. LENGTH OF STAY IN 1b D O A					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Charlestown					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HMCN Hospital										d. STREET ADDRESS 1														
3. NAME OF DECEASED (Type or print) First George Middle Emory Last Norman										4. DATE OF DEATH Month June Day 9 Year 1959														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb 16 1904			9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Carpenter					10b. KIND OF BUSINESS OR INDUSTRY Boat Builder					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Charles E. Norman										14. MOTHER'S MAIDEN NAME Bertha M. Galloway														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					17. INFORMANT Address Mrs. Idella G. Jones, Charlestown, Md.														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 819X Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Slight cut on left forearm (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 15 min.														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit a concrete abutment																			
20c. TIME OF INJURY Hour 9:45 p. m. Month, Day, Year 6-9 1959					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Charlestown Rt 267					20f. (City or town) (County) (State) Charlestown, Cecil, Md									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																								
ACTUAL SIGNATURE R.C. Dodson M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED									
EXAMINER'S NAME (Type) R.C. Dodson M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					June 10, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 6-13-1959					22c. NAME OF CEMETERY OR CREMATORY Charlestown					22d. LOCATION (City, town, or county) (State) Charlestown Cecil Co., Md									
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant										ADDRESS North East, Maryland					24a. REC'D BY REGISTRAR JUN 12 '59					24b. REGISTRAR'S SIGNATURE Arthur A. Grant				



100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH RECORD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		SEX Male		AGE 35		DATE OF BIRTH June 10, 1909	
PLACE OF BIRTH Maryland		CITY Baltimore		STATE Maryland		COUNTRY USA	
OCCUPATION None		EDUCATION None		RELIGION None		MARRIAGE None	
DATE OF DEATH June 10, 1959		PLACE OF DEATH Home		CITY Baltimore		STATE Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		MEDICAL EXAMINER J. H. Jones, M.D.		DATE OF EXAMINATION June 10, 1959	
SIGNATURE OF MEDICAL EXAMINER J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.	
DATE OF DEATH June 10, 1959		PLACE OF DEATH Home		CITY Baltimore		STATE Maryland	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		MEDICAL EXAMINER J. H. Jones, M.D.		DATE OF EXAMINATION June 10, 1959	
SIGNATURE OF MEDICAL EXAMINER J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.		SIGNATURE OF WITNESS J. H. Jones, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6668

Item 9 Film G244 6-25-59 et

CERTIFICATE OF DEATH

06671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>PAYNE</u> Last <u>WELLS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1923</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u> Hours <u>35</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL KURILLA</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. STEC</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROBERT A. PAYNE</u>		Address <u>NR. ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mammary G. I. Tumor Hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE LEUKEMIA</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 weeks?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. Month <u>—</u> Day <u>19</u> Year <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:12</u> , 19 <u>59</u> , to <u>6:45 P.M.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6:12</u> , 19 <u>59</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Stavrakis</u>		DATE SIGNED <u>6/12/59</u>	
PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS, M.D.</u>		ADDRESS (Street, city or town, state) <u>134 W. MAIN ELKTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>IMMACULATE CONCEPTION - NR. ELKTON, MD</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>ELKTON, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUN 16 '59</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06672

6684

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>4hrs.15minutes</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>Aiken Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM LEYBURN PERRY</b>			4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1909</b>		9. AGE (In years last birthday) <b>49</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General repairs</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>REDDEN PERRY</b>			14. MOTHER'S MAIDEN NAME <b>VIOLA GAY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-II 218-18-1991</b>		17. INFORMANT Address <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, intraventricular right</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>Unknown</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>R. C. DODSON</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-7-59</b>	
EXAMINER'S NAME (Type) <b>R. C. DODSON, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio Furnace</b>	
22d. LOCATION (City, town, or county) <b>Principio, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. A. PATTERSON &amp; SON</b>			24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kneass</b>
ADDRESS <b>Perryville, Md.</b>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-1-29		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Attorney		8. MARITAL STATUS Single		9. EDUCATION High School Graduate	
10. PLACE OF DEATH Baltimore, Maryland		11. TIME OF DEATH 10:00 PM		12. CAUSE OF DEATH Suicide	
13. MANNER OF DEATH Suicide		14. SIGNATURE OF EXAMINER [Signature]		15. DATE 6-11-68	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]	
19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]		21. SIGNATURE OF WITNESS [Signature]	
22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]	
28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]	
34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]	
40. SIGNATURE OF WITNESS [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]	
52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]	
58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]	
64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]	
70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]		81. SIGNATURE OF WITNESS [Signature]	
82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]	
88. SIGNATURE OF WITNESS [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]	
94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]	
100. SIGNATURE OF WITNESS [Signature]		101. SIGNATURE OF WITNESS [Signature]		102. SIGNATURE OF WITNESS [Signature]	

68-11-68



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06673

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X North East</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Rural Delivery</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Drenerd</b> Middle <b>A.</b> Last <b>Reynolds</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>7</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7-24-25</b>	
<b>9. AGE</b> (In years last birthday) <b>33</b> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.		<b>IF UNDER 24 HRS.</b> Hours      Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Agent</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Perryville, Md.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Drenerd M. Reynolds</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Heverin</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW II</b>				<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address <b>Not ascertainable Hosp. Records, VA Hospital, Perry Point, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Billiary Peritonitis traumatic liver due</b>  <b>823X</b> <b>DUE TO</b> <b>to rupture of common duct</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>823X</b> </div> <div style="width: 45%;"> <b>(b)</b>  <b>DUE TO</b> </div> </div> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <b>16 days</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile hit a tree</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      a. m.      p. m. <b>5-22</b> <b>19 59</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>RT 7</b>		<b>20f. (City or town) (County) (State)</b> <b>North East, Cecil, Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i>				<b>DATE SIGNED</b> <b>6-7-59</b>			
<b>EXAMINER'S NAME (Type)</b> <b>R. C. DODSON, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, 22b. DATE THEREOF</b> (Specify) <b>6-7-59 Removal</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>North East Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>North East, Md.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Joseph R. Brant</i>				<b>24a. REC'D BY REGISTRAR</b> <b>JUN 9 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Evans</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06674	
6686										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit					c. LENGTH OF STAY IN 1b Life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary A. Stewart					4. DATE OF DEATH Month Day Year June 7, 19 59						
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-26-1875		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Black					14. MOTHER'S MAIDEN NAME Hannah Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		INFORMANT Address Horace A. Stewart Port Deposit, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Myocardial infarction DUE TO (b) Hypertensive Cardiovascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 weeks INTERVAL BETWEEN ONSET AND DEATH 10 yrs.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 5, 1959, to Jan 7, 1959, that I last saw the deceased alive on Jan 6, 1959, and that death occurred at 6:10 P. M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Dr. G.H. Richards Jr. M.D.					ADDRESS (Street, city or town, state) DATE SIGNED 6/8/59						
PHYSICIAN'S NAME (Type) Dr. G.H. Richards Jr.											
22a. BURIAL, CREMATION, REBURY (Specify) Burial			22b. DATE THEREOF 6-10-1959		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery			22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural			
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons					ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hanna		

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6687

CERTIFICATE OF DEATH

06675

Reg. Dist. No.

1. PLACE OF DEATH Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cocolora	c. LENGTH OF STAY IN 1b 39 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cocolora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Marian Haviland Tatum		4. DATE OF DEATH Month Day Year June 26 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1869
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Merritt M. Haviland		14. MOTHER'S MAIDEN NAME Lydia M. Haviland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Lloyd Balderston Cocolora, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral Sclerosis (b) Chronic Myocarditis (c) Arterio-Sclerosis - CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs 6 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 5, 1959, to June 26, 1959, that I last saw the deceased alive on June 26, 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE CLARENCE I. BENSON		ADDRESS (Street, city or town, state) DATE SIGNED 6/27/59	
PHYSICIAN'S NAME (Type) CLARENCE I. BENSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/29/1959	22c. NAME OF CEMETERY OR CREMATORY Woodside Cem.	22d. LOCATION (City, town, or county) (State) Brinklow Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thomas M. Mullen		24a. REC'D BY REGISTRAR DATE JUN 30 '59	
ADDRESS Rising Sun, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore, Md.		COUNTY Baltimore	
SEX Male		COLOR White	
AGE 45 yrs.		DATE OF BIRTH Feb. 4, 1890	
PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH Feb. 10, 1935	
NAME OF DECEASED Lawrence H. Hays, Jr.		NAME OF FATHER Lawrence H. Hays, Sr.	
NAME OF MOTHER Mary Hays		NAME OF SPOUSE Mary Hays	
OCCUPATION Engineer		CAUSE OF DEATH Coronary thrombosis	
PLACE OF INTERMENT St. Paul's Episcopal Church		DATE OF INTERMENT Feb. 12, 1935	
SIGNATURE OF PHYSICIAN J. Edgar Smith, M.D.		SIGNATURE OF REGISTRAR J. Edgar Smith, M.D.	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6669

## CERTIFICATE OF DEATH

06676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>513 North Street</u>			d. STREET ADDRESS <u>513 North Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie W. Winsinger</u>			4. DATE OF DEATH Month Day Year <u>June 26 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1875</u>	9. AGE (If years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>William Gray</u>		
14. MOTHER'S MAIDEN NAME <u>Addelaide Wallace</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>Margaret P. Biddle</u> Address <u>263 E. Main St. Elkton, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Elkton</u>			(County) (State)		
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>June 26, 1959</u> , that I last saw the deceased alive on <u>June 24</u> , 1959, and that death occurred at <u>1:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>June 26, 1959</u>					
ACTUAL SIGNATURE <u>Donald M. Pippin</u> M.D.			PHYSICIAN'S NAME (Type) <u>Elkton, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u> ADDRESS <u>Donald M. Pippin</u> <u>Md.</u>			24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knaus</u>









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06678

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON R.D. 2</u>		c. LENGTH OF STAY IN 1b <u>20yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON, R.D. 2.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GEORGE</u> Middle <u>WILLIAMS</u> Last				<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-23-1902</u>			
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gardens and farm Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Williams</u>				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-93-1117</u>		17. INFORMANT Address <u>Mrs. George Williams Elkton, R.D. 2 Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-25-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Bohemia Manor, Md.</u>		24a. REC'D BY REGISTRAR <u>MIN 29 '59</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Bell</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

5091-5092

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6689

## CERTIFICATE OF DEATH

06679

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-92</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	11. IF UNDER 24 HRS. Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Williams (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Busch (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-22-0605</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis diffuse due to extravasated contents of viscera</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Resection of large bowel for adenocarcinoma of the rectum (6-12-59)</b> (c) <b>154X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3</b> , 19 <b>59</b> , to <b>June 15</b> , 19 <b>59</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.		22. LOCATION (City, town, or county) (State) <b>Proctorville, Harford Co., Md.</b>	
ACTUAL SIGNATURE <b>J. L. GAREY</b>		DATE SIGNED <b>6-16-59</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/18/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Waters Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Proctorville, Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>TARRING FUNERAL HOME, ABERDEEN, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUN 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00078

CERTIFICATE OF DEATH

00088

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of registrar: [illegible]  
9. Date of registration: [illegible]  
10. Place of registration: [illegible]



PENNINGTON & CO., ROYAL DE GRACE, MD.

Removal

W. L. LIND, M.D.

Perry Point, Maryland

V. A. Hospital, Perry Point, Md. 1-1-50

SHOEN

June 20, 1950

June 19, 1950

Maryland

Geoff

Pocomoke

12 days

Perry Point,

Veterans Administration Hospital

WINSON

(A1)

LEASH

June

November 27, 1946 02

Male Negro

Laborer

Unknown

Watersville, Maryland

U.S.A.

Juan Maria

Levin Wilson

Yes WVI

217097207

Hospital Records, VA Hospital, Perry Point,

Chronic pyelonephritis

Years

Blind and chronic pyelonephritis and lung abscess

2 weeks

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

## CERTIFICATE OF DEATH

Reg. Dist. No. 06681

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union</b>				d. STREET ADDRESS <b>120 Booth St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Madeline</b> Middle <b>B</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4 1882</b>		9. AGE (In years last birthday) yrs. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry worker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Biddle</b>				14. MOTHER'S MAIDEN NAME <b>Martha Sewell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>221-10-0190</b>		17. INFORMANT Address <b>Nora Braywood 120 Booth St Elkton, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Renal Disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 June 1959</b> , to <b>29 June 1959</b> , that I last saw the deceased alive on <b>29 June 1959</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Klaus H. Huebner</b>				ADDRESS (Street, city or town, state) <b>North East, Md</b>		DATE SIGNED <b>29 June '59</b>	
PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-3-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

